

DEPARTMENT OF HUMAN SERVICES

MAINECARE HOME HEALTH ADMIT/DISCHARGE FORM (AGE 21 AND OLDER)

Member: _____ **Provider Name:** _____

MaineCare Number: ☐☐☐☐☐☐☐☐☐ **Provider Telephone:** _____

Provider Contact Person: _____ **Provider Fax:** _____

☐ **NEW ADMIT TO YOUR AGENCY** (send only to BEAS Fax # 287-9231) **Original Start of Care Date:** ____/____/____

☐ **Psychiatric Medication Services ONLY:** Member has a severe and disabling mental illness that meets the eligibility requirement set forth in Section 17. The only service covered is medication administration or monitoring.
RN Start of Care: ____/____/____

(ANY ADDITIONAL HOME HEALTH SERVICES REQUIRE PRIOR AUTHORIZATION UNDER THIS EXEMPTION)

Current Plan of Care Services **Plan of Care started with a verbal order** ☐ Yes ☐ No

	Start of Care	PA REQUIRED AFTER THE FIRST 60 DAYS FOR ALL CATEGORIES OF SERVICE IN THIS SECTION
<input type="checkbox"/> * RN - Teach and Train	____/____/____	
<input type="checkbox"/> * RN Assessment Management ♦	____/____/____	♦ For new/recent medical condition w/in past 30 days
<input type="checkbox"/> RN - Skilled Nursing	____/____/____	
<input type="checkbox"/> Psychiatric Medication Services (when receiving additional services)	____/____/____	
<input type="checkbox"/> Home Health Aide	____/____/____	
<input type="checkbox"/> MSW (not allowed as stand alone – must also have RN, PT, OT or ST)	____/____/____	

*** Limited to 120 days per admission**

<input type="checkbox"/> Physical Therapy	____/____/____	PA IS REQUIRED IF PT EXCEEDS 20 VISITS/ FISCAL YEAR
<input type="checkbox"/> Occupational Therapy	____/____/____	PA IS REQUIRED IF OT EXCEEDS 20 VISITS/ FISCAL YEAR
<input type="checkbox"/> Speech Therapy	____/____/____	PA IS REQUIRED IF ST EXCEEDS 35 VISITS/FISCAL YEAR

DISCHARGED TO (SEND ONLY TO BEAS FAX # 287-9231)

HOME HEALTH END DATE

Long-term Care Program (name) _____ (End Date = End of AP)	Date _____
Home, Medicare/3 rd party payer service	Date _____
Home, no service	Date _____
Hospital	Date _____
Residential Care (name) _____	Date _____
Nursing Facility (name) _____	Date _____
Death	Date _____

Person completing this form: _____ **Date** _____